Lafayette Bone and Joint Clinic **Dr. Daniel Hodges**

Patient Information Sheet

For return patients only

****ENTIRE FORM MUST BE COMPLETELY FILLED OUT****

Patient # _____

Today's Date: _____

Patient's Name: _____ Age: _____

HISTORY OF PRESENT ILLNESS

Please describe the type of medical problem or symptoms that you are being seen for since your last visit:

_____

_____

****

SYMPTOMS

Indicate Right, Left or Both

_____ Neck
_____ Shoulder ___Right ___Left ___Both
_____ Arm ___Right ___Left ___Both
_____ Elbow ___Right ___Left ___Both
_____ Wrist ___Right ___Left ___Both
_____ Hand ___Right ___Left ___Both
_____ Back
_____ Hip ___Right ___Left ___Both
_____ Knee ___Right ___Left ___Both
_____ Leg ___Right ___Left ___Both
_____ Ankle ___Right ___Left ___Both
_____ Foot ___Right ___Left ___Both
_____ Other _____

Timing of Symptoms

_____Constant
(Symptoms all day, everyday)
_____Occasional
(Symptoms off & on, but NOT every day)
_____Intermittent
(Symptoms off & on every day)

Description of Symptoms

_____ Aching
_____ Throbbing
_____ Burning
_____ Tingling
_____ Stabbing
_____ Catching
_____ Popping
_____ Grinding
_____ Sharp
_____ Dull

What Makes Condition Worse

_____ Walking
_____ Lying down
_____ Bending
_____ Stooping
_____ Sitting
_____ Depression
_____ Standing
_____ Writing
_____ Reaching Overhead
_____ Stair Climbing
_____ Tension
_____ Anxiety
_____ Lifting
_____ Other: _____

Modifying Factors What makes it better

_____ Medication
_____ Rest
_____ Physical Therapy
_____ Heat
_____ Cold
_____ Other:_____
_____
_____

Are you in pain:	**Pain Level**	**Associated Signs & Symptoms**
_____ Less than 8 hours a day	10 Severe Pain	_____ Numbness, where_____
_____ 8-12 hours per day	9	_____ Weakness, where_____
_____ 12-18 hours per day	8	
_____ 18-24 hours per day	7	
	6	
	5	
	4	
	3	
	2	
	1	
	0 No Pain	

How does the pain affect your sleep since your last appointment?

	Always	Sometimes	Never
Trouble falling asleep	_____	_____	_____
Medications needed for sleep	_____	_____	_____
Awakened by pain	_____	_____	_____
Average number hours of sleep	____ 1-2 hours	____ 2-4 hours	
	____ 4-6 hours	____ 6-8 hours	
	____ over 8 hours		

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

Are there any changes with you or your immediate families medical and social history since your last office visit? No ____ Yes ____

If yes, please explain: _____

_____

Any type of cancer: _____

Work Status as of today:

_____ Employed as _____ _____ Retired since: _____

_____ Workers' Comp while employed by _____

_____ Unemployed since: _____

_____ Receiving disability compensation benefits

GENERAL INFORMATION

Please list any medications or herbal supplements you are currently taking:

Name	Dose	How often is it taken:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications? Please list the name of the medication and the reaction caused by taking the medication: _____

_____

REVIEW OF SYSTEMS: Are you **CURRENTLY** experiencing any of the following symptoms? Please check yes or no.

NO	YES	General
____	____	Weakness
____	____	Tiredness
____	____	Chills
____	____	Fever
____	____	Night Sweats
____	____	Diabetes or problems with blood sugar
____	____	Problems with blood (i.e. clotting)
____	____	Liver Disease
____	____	Difficulty with sleeping

CIRCLE ONE Lack of appetite / Excess of appetite / N/A

CIRCLE ONE Weight loss / Weight gain / N/A

NO	YES	Cardiovascular
____	____	Chest pain, tightness or squeezing
____	____	Shortness of breath lying down
____	____	Need to sit up to breath
____	____	Heart racing
____	____	Irregular heart beat (palpitations)
____	____	Heart murmur
____	____	Swelling of the legs
____	____	Varicose Veins
____	____	Leg pain at rest
____	____	Leg pain with exertion
____	____	Blue/purple discoloration of Hands/feet

NO	YES	Gastrointestinal
____	____	Nausea
____	____	Vomiting
____	____	Heartburn
____	____	Abdominal pain
____	____	Bright red blood in stools
____	____	Black stools
____	____	Gastritis or Ulcers

CIRCLE ONE Diarrhea / Constipation / N/A

NO	YES	Urinary
____	____	Pain or burning on urination
____	____	Frequent urination
____	____	Extreme urge to urinate
____	____	Difficulty starting urinary stream
____	____	Difficulty stopping stream
____	____	Kidney stones
____	____	Erectile/Sexual dysfunction

NO	YES	Musculoskeletal
____	____	Neck pain
____	____	Shoulder or arm pain
____	____	Back pain
____	____	Pain down the legs
		Right side ____ Left side ____
____	____	Painful joints
____	____	Swelling of any joints
____	____	Redness of any joints
____	____	Stiffness of any joints
____	____	Deformities of joints or extremities

NO	YES	Neurologic
____	____	Seizures
____	____	Headaches
____	____	Blackouts
____	____	Dizziness
____	____	Paralysis or weakness of limb
____	____	Loss of sensation

CIRCLE ONE Double Vision / Blurred Vision / N/A

NO	YES	Psychiatric
____	____	Nervousness
____	____	Depression
____	____	Difficulty with memory for past events
____	____	Difficulty with problem solving
____	____	Anxiety

NO	YES	Respiratory
____	____	Sleep apnea
____	____	C.O.P.D
____	____	Asthma

_____

Signature of Patient **Date**